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ABSTRACT

The first section of this Technical Committee Report provides a brief summary of the major health problems of the elderly. Problems are categorized under the general headings of health maintenance, chronic illness, mental illness, multiple impairments, demographic characteristics, manpower (geriatric medicine, nursing, and other health professions), prevention, death, Medicare, and minorities. Supporting discussions are included for each category as well as references to more extensive information. The second part of this report recommends changes in policies and programs to better address the health care needs of the aged. The eight recommendations listed in this section, predicated on the conviction that a national health policy for the elderly should focus on the quality of life and emphasize maximum functional independence, are categorized in terms of: (1) useful work; (2) primary care; (3) allied health professionals; (4) Medicare reforms; (5) long-term care coordinating service; (6) humane terminal care; (7) professional training in geriatrics and gerontology; and (8) research in geriatrics and gerontology. An executive summary of this report is also included. (NRB)

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WHITE HOUSE CONFERENCE ON AGING, 1981

Health Services

Report and Executive Summary of the Technical Committee

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the 1981 White House Conference on Aging

Report of Technical Committee on HEALTH SERVICES

TCR-10

NOTE: The recommendations of this document are not recommendations of the 1981 White House Conference on Aging, or the Department of Health and Human Services. This document was prepared for the consideration of the Conference delegates. The delegates will develop their recommendations through the processes of their national meeting in late 1981.

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I. HEALTH CARE NEEDS OF THE ELDERLY

The health experiences of older persons differ considerably from those of other segments of the adult population. As a consequence, their need for health care services also differs, as the following vignettes partially illustrate.

Mr. Jones has just celebrated his 65th birthday. He is white, married, with two grown children, both of whom have moved to other states. He is still working as an accountant with a large insurance company and earns about $28,000 a year. He and his wife own their own home in a midwestern suburb. He is about 15 pounds overweight, with slightly elevated blood pressure, but otherwise in good health. His company would permit him to stay on until age 70, and he would like to do so. But Mrs. Jones is eager for him to retire so that they can move to Florida and live in a mobile home, which would be less work for her as well as for him. The consequences of Jones' decision regarding retirement—both the health and economic consequences—are important to him, his wife, his employer, and society at large.

Mrs. Smith has just celebrated her 75th birthday. She is black, divorced, and has five living children, aged 45 to 58, only two of whom still live in the same community, an eastern big-city ghetto. Mrs. Smith has worked hard all of her life, mostly in low-paying household or hotel-cleaning jobs. There was never any formal retirement; she just stopped when she could no longer work. She lives on her Social Security pension supplemented by SSI, food stamps, and other welfare programs. She is about 50 pounds overweight, has diabetes, poor eyesight, and no teeth, but is still able to take care of herself and her little apartment. Between Medicare and Medicaid, her medical bills are covered. But she and her children worry about the future. Should she continue to live alone in her dingy but expensive little apartment, largely isolated by big-city traffic and crime, with practically no opportunity for exercise or even fresh air; or should she give up her independence altogether and move into a boarding home in another community, as recommended by her social worker?

Mrs. Brown has just celebrated her 85th birthday. She is white, worked 40 years as a school teacher, and was forced to retire at age 65, although she was in good health. She has no children. She and her husband managed to get by on Social Security and his small private pension until his death five years ago. From that point on, she failed rapidly. His pension ceased automatically. The Social Security payment dropped sharply. She had to give up her home and moved into a tiny apartment which still consumed most of her income. She has practically no social contacts. A year ago she broke her hip on the way home from the market and has been institutionalized ever since, first in a hospital, then in a nursing home. After completely exhausting all her savings, she is now on Medicaid and probably destined to spend whatever time she has left in bed and wheelchair in this home. She would much prefer to leave if some sort of sheltered living arrangement were possible—perhaps in a boarding home or foster home. However, there are no facilities of this type in her community.

These brief case histories suggest some of the problems the elderly face. The first section of our report provides a brief summary of the major health problems of the elderly presented as a series of ten factual statements and followed by supporting discussion. References guide the interested reader to more extensive information. The second part of the report recommends changes in policies and programs so that we can better address the health care needs of the aged.

A. Most of the elderly, especially the "young-old" (age 65 to 74), are relatively "healthy" and are primarily concerned with maintaining their health.

In the early 1970's about 5 percent of the elderly (those aged 65 and older) were institutionalized; about 4 percent were in nursing homes.[1] By 1978, the proportion in nursing homes had increased to 5 percent.[2] Today about 1.3 million elderly persons live in nursing homes, and about one in five of those still living in the community will spend some time in such a place before they die.[3]

A large majority of those 23 million, however, consider themselves relatively healthy. In 1975, the National Center for Health Statistics (NCHS) conducted a household survey of the civilian, noninstitutionalized population age 65 and over and found that 69 percent rated their health as "good" or "excellent" and only 9 percent as "poor".[4] This does not imply the complete absence of chronic impairments but does mean that such impairments do not significantly interfere with physical and social functioning.

Evidence that the elderly wish to limit the interference caused by physical problems came from over 155 community forums held in New Jersey during 1980 in preparation for the 1981 White House Conference on Aging. The health issue receiving the greatest attention at those forums was the need for "eye, ear, and dental coverage under Medicare".[5] Correction of chronic sensory deficits can avert serious illness, falls, or emotional withdrawal and thereby help older people remain physically and mentally active as well as socially involved as long as possible.[6,7]

Those three components—the physical, the mental, and the social—interact in making an individual healthy. A recent study of patients with coronary heart disease at Duke University Medical Center, for instance, found that 70 percent of those who were working full-time while being treated with medication got relief from their angina compared to only 42 percent of those who were not working.[8] In the words of the physician who conducted the study:

> Perhaps doctors should stop advising their coronary patients to quit work. . . . Keeping these patients at work may actually help them to cope better with their disease. . . . The sense of purpose, feeling of doing something useful that many people get from full-time work, probably contributes to a coronary patient's ability to get relief from angina.

In short, useful work—either paid or volunteer—and its concomitant social involvement appear to relate directly to physical and mental health.

B. Older persons who do become ill are likely to have a mixture of both acute and chronic illnesses and disabilities, in contrast to younger adults, who usually have only single acute illnesses. The multiple illnesses affect multiple organ systems simultaneously, and treatment of one disorder may provoke malfunction in another organ system or aggravate a coexisting disease. The older person with multiple diseases is therefore at greater risk of experiencing over- or undertreatment or of having a treatment "misadventure." In addition, the older person frequently does not know precisely where to go for health care services.

In 1976 NCHS found that chronic conditions (including heart disease, cancer, stroke, diabetes, arthritis, and emphysema) accounted for 87 percent of all deaths for those age 65 and over and for 81 percent of their days of restricted activity (see Figures 1, and 2).[9] Of all persons over age 65, 45 percent report some chronic limitation of activity (Figure 3), although for many, particularly

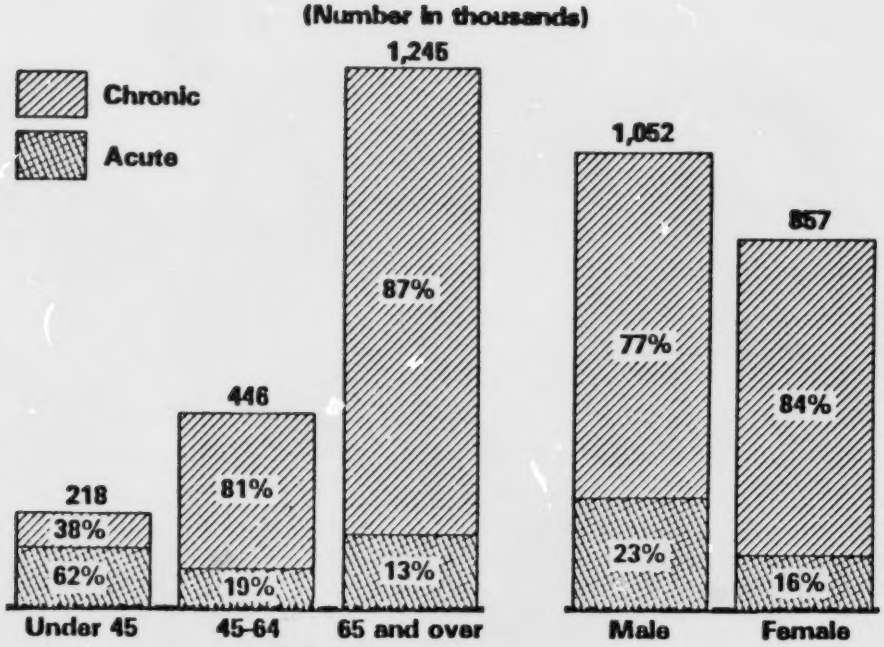

Figure 1: Distribution of Deaths by Cause, According to Age and Sex, 1976.

SOURCE: M.G. Kovar and T.F. Drury "Elderly People" The Population Age 65 and Over" Presented at APHA meeting, Detroit, October 1980.

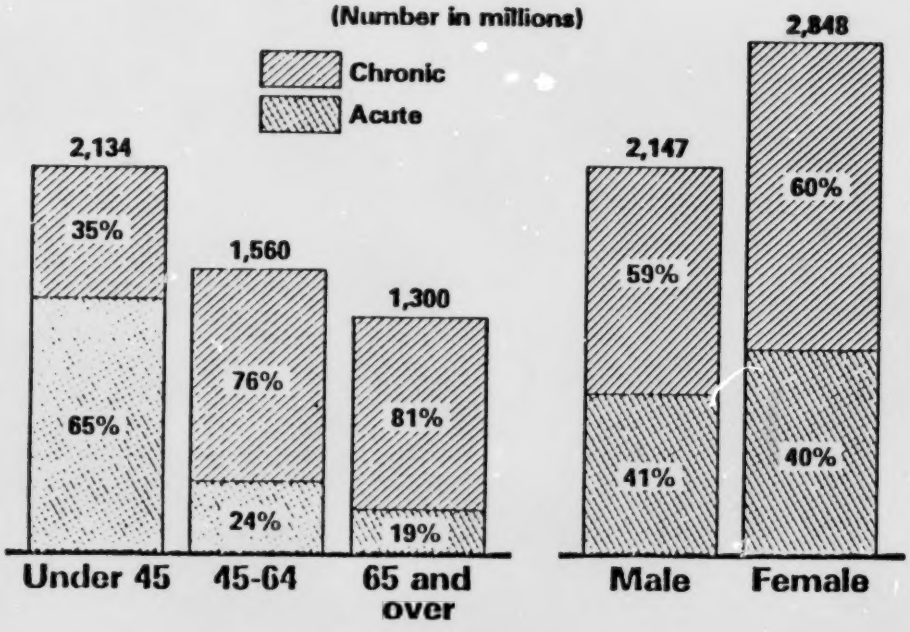

Figure 2: Distribution of Days of Restricted Activity by Type of Condition, According to Age and Sex, 1976

SOURCE: See Figure 1.

the young-old, this does not necessarily result in serious dysfunction. Table 1 compares the frequency of chronic conditions and resulting limitations of activity in older persons with that of the population aged 45 to 64.

Two chronic conditions cause almost half the limitations. Heart disease restricts about 25 percent of the elderly and arthritis, another 23 percent.[10] Other limiting conditions include orthopedic impairments (10 percent), visual impairments (10 percent), and hypertension (9 percent). Not only is the pattern of disease different for older people, the presentation of diseases and their management also require special knowledge and skills. For instance, ample evidence now exists from the work of investigators such as Shock and others[11,12] that virtually every organ system in the older person functions at reduced capacity. This includes decreased muscle strength, decreased respiratory capacity, decreased cardiac output, decreased renal function, slowed reaction time, decrease in tissue volume, etc. Under ordinary circumstances these reductions do not necessarily result in decreased functioning of any of these organ systems. Instead, the older person experiences a diminished reserve capacity in virtually all organ systems so that relatively modest additional stresses can cause decreased functioning. For example, pneumonia can trigger heart failure, which may necessitate hospitalization. The rapid change in environment may lead to incontinence and mental disorientation. These dysfunctions may finally cause the elderly person to be institutionalized in a nursing home.

Table 1
Chronic Illness and Associated Disability for Various Age Groups

Health Status	Age Group		
	45-64	65-74	75+
Number of chronic conditions per person	.41[a]	.65	.87
Activity limited by chronic conditions	24	42	56
Bed disability days per year	9.3	10.3	17.4
Days of restricted activity per year	28.0	34.0	46.0
Percent who perceive health as good or excellent	76[a]	69	68

SOURCE: Composite data from the Health Interview Survey, U.S. DHEW National Center for Health Statistics, Series 10; and special analyses of NHIS data by Rand.

[a] Ages 55-59.

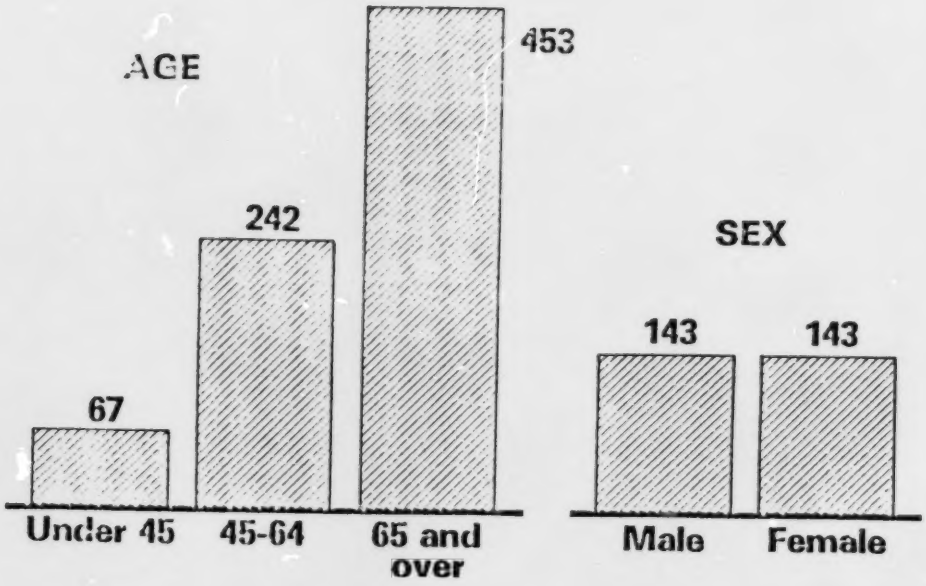

Figure 3: Rate per 1,000 Population of Persons with Limitation of Activity Due to Chronic Conditions, According to Age and Sex, 1976

SOURCE: See Figure 1.

Because of the delicate balance of systems in older persons, a keen awareness of how the treatment of one disorder may affect other conditions must be brought to the treatment of the elderly. In order to avoid the negative consequences of both over- and undertreatment, physicians must assist their patients in taking more responsibility for their health. Physicians must teach patients to observe and rapidly report both positive improvements resulting from treatment and undesirable side effects occurring subsequent to any treatment change. Even the most common disorders such as congestive heart failure, hypertension, diabetes, and arthritis require the physician's and other caregivers' exacting skill, as well as vigilant collaboration between the patient and his family.

Despite the increased prevalence of chronic conditions and restricted activity, the elderly do not make heavy demands for services. As Table 2 shows, on average they make only one more physician visit a year than do other segments of the population. Use of hospitals goes up with age, but dental care actually decreases. The striking increase is in the use of nursing homes. Those over age 75 are almost thirty times as likely to be in a nursing home as those age 45 to 64 and eight times more likely than those aged 65 to 74. If we continue to use these institutions at the present rate, by the year 2030 we will have over 2.6 million persons age 65 or older in nursing homes.

In older persons and in the young, manifestations of both acute and chronic illnesses may differ for the same diseases, leading to potential delay and potential misdiagnosis, rather than to timely and appropriate treatment and rehabilitation. For example, in older patients, a heart attack may not manifest itself with the typical chest pain, shortness of breath, sweating, or collapse commonly seen in younger or middle-aged persons. The patient may take to bed, become gradually confused, disoriented, and listless, without having specific signs of the heart condition. Similarly, infectious disease, commonly manifested by increased temperature, rapid pulse, and localized pain, may be "silent" in the older person, with general debility, disorientation, and listlessness as the only symptoms.

Elderly persons may also experience illnesses unique to their age group. One such illness is accidental hypothermia, a dangerous lowering of body temperature due to prolonged exposure in inadequately heated houses. The reverse of this is hyperthermia, a dangerous elevation of body temperature due to decreased ability to diffuse heat in the summer months.

Table 2
Health Service Utilization by Various Age Groups

Health Service Utilization	Age Group		
	45-64	65-74	75+
Mean number of physician contacts per year	5.7	6.9	6.8
Mean number of dental visits per year	1.8	1.3	0.8
Percent seeing a physician in past year	76[a]	80	81
Percent seeing a dentist in past year	58.8	34.7	22.7
Nursing home residents per 1000 persons	3.7	12	97.3[b]
Nonfederal hospital days per non-institutionalized person	1.75	3.28	5.86
Operations per 1000 persons	124.6	165.9[c]	

SOURCES: Composite data from the Health Interview Survey, U.S. DHEW National Center for Health Statistics, Series 10; and special analyses of NHIS data by Rand.

[a] Rate for ages 50-64.

[b] Rate for ages 75-84 = 58.9, and for 85+ = 236.6.

[c] Rate for ages 65+.

Thus, health care providers, patients, and relatives need a new understanding of how illness and disease manifest themselves in older persons so that they can assure early intervention, correct diagnosis, appropriate treatment, and restoration of functioning.

Medications used in the treatment of both physical and mental disorders have significantly altered effects in older patients, who often require multiple medications. Drug interactions and adverse drug reactions add to the health care burdens of an already burdened segment of the population.

Medications are absorbed, metabolized, stored, and excreted differently in the elderly than in the young. For the vast majority of drug classes, this difference means that smaller amounts of drugs are required to achieve the desired therapeutic result. The point has particular relevance to such major classes of drugs as the psychotropic drugs, cardiovascular drugs, antihypertensive drugs, and diuretics.

Multiple illnesses of the elderly require multiple types of medications (and many persons also take still more over-the-counter drugs). Many of these medications interact with one another, either to increase or to decrease their relative effectiveness. In conjunction with other drugs, they may cause "misadventures" in drug taking, resulting in such undesirable side effects as delirium, orthostatic hypertension, unsteadiness of gait, or accidental falls.

Because the elderly have such vulnerable, delicately balanced sets of interacting organ systems, powerful medications, badly needed for the correction of physiological disabilities, may exert powerful but unanticipated or undesired effects. For example, using aspirin to treat arthritis may cause gastric ulceration and bleeding. The use of steroids in an older woman to treat arthritis or allergic conditions such as asthma or skin disorders may worsen osteoporosis and the resultant compression fractures in the spine. Moderate doses of diuretics used in the treatment of hypertension may result not only in orthostatic hypotension but in electrolyte depletion and reversible organic brain syndrome with delirium.

As currently designed, the health care system does not reach out to the older people and inform them how the system can serve them. Thus, elderly persons often do not know where to turn for help, what to look for, or what services they are eligible for. They have no simple way of evaluating the quality of services they receive.

With notable exceptions, health care services in the United States are provided separately from health-related social support services, which many older persons also require to maintain independent functioning. Separate professional education pathways and separate funding mechanisms for health and social services strongly reinforce this separation.

C. Fifteen percent of all older people living in the community and an astonishing 50 to 70 percent of elderly living in institutions suffer from serious mental and/or emotional problems. Mental disorders may be the principal cause of disability among the elderly or they may complicate the health status of those elderly with major physical problems. Mental problems common among the elderly include depression, anxiety states, paranoia, and alcoholism, as well as reversible and irreversible dementias, i.e., serious intellectual and memory disorders. The frequency of suicide, especially among males, greatly exceeds rates experienced by younger persons.

Mental health problems arising late in life are virtually unrecognized and practically unattended. Substantially larger numbers of the old than the young experience both functional and organic brain syndromes. As shown in Figure 4, approximately 15 percent of persons over age 65 residing in the community are experiencing major psychiatric disorders.[13,14] Of these, approximately half have functional disorders in which there is intact brain functioning; the other half experience psychiatric disorders based on temporary or permanent decrease in brain functioning.

The most common functional psychiatric disorders, all of which are potentially responsive to treatment, include depressive reactions, transient situational disturbances, acute and chronic anxiety states, paranoid states, hypochondriasis, and late-life-onset alcoholism.[15] Many of these disorders may be viewed as responses to both an increasingly hostile environment and the decreasing support systems many elderly persons have. Nevertheless, effective treatment methods exist today to overcome virtually all these disorders. Older persons respond remarkably well to appropriate treatment and intervention when such treatments are adapted to their specific needs, circumstances, and limitations.[16-18]

Even serious disorders can be treated. Among the 7.5 percent of elderly persons who suffer from serious memory deficit and general intellectual decline,[19-21] a fifth suffer from disorders that are potentially reversible through appropriate treatment and intervention. The remaining four-fifths suffer from irreversible brain damage. Nevertheless, even among these persons, the treatment of associated or secondary symptoms can signficantly improve functioning, and effective procedures can maintain intellectual functioning despite existing brain deficits. The same may be said for the 50 to 70 percent of institutionalized individuals suffering from other significant psychiatric disorders (for the most part senile dementia or memory deficit as a result of multiple strokes) and for significant numbers suffering from severe depression, functional paranoia, acute and chronic anxiety states, and other situational disturbances.

Although psychiatric disorders are frequent and respond remarkably well to treatment, such care is in short supply. Only 1.5 percent of all mental health resources are expended on elderly patients. According to recent studies, many outpatient and inpatient facilities have no specialized programs for the treatment of mental disorders of the elderly. In institutional settings especially, where mental disorders may be the major cause of institutionalization and disability, almost no mental health services are available.[22,23] As many as two-thirds of older persons in institutions receive psychotropic medications, but very few have had a psychiatric evaluation.[24] The lack of coverage for mental

health services condemns most of these individuals to continued mental and emotional suffering and disability. Considerable misunderstanding exists about the nature and treatability of mental disorders in old age, their prevalence, and their potential for reversal.

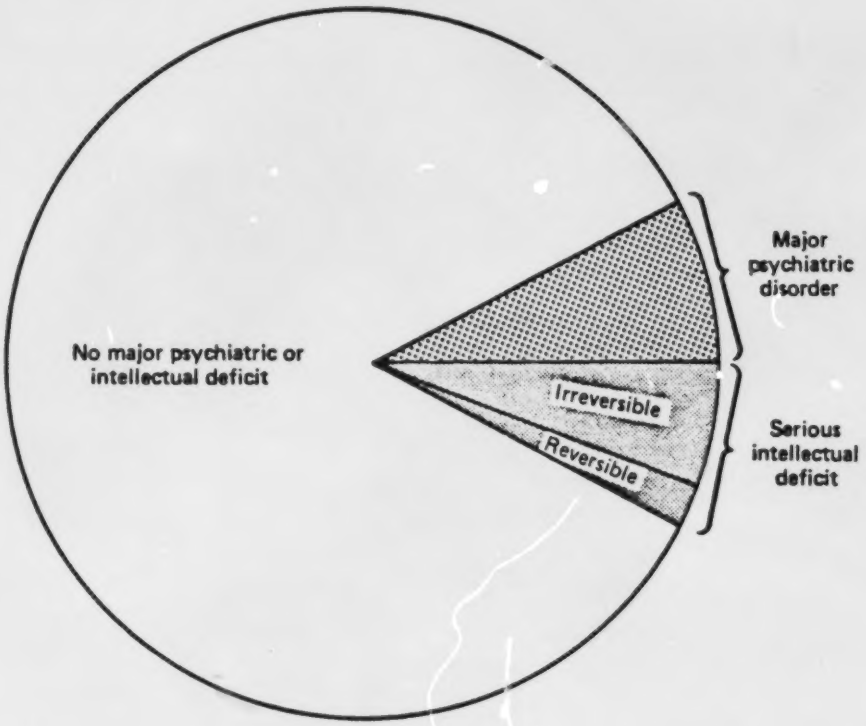

Figure 4: Frequency of Major Types of Mental Health Problems Among the Elderly

D. Older persons experiencing health and mental health problems frequently have associated disabilities and impairments including social isolation and financial deprivation. Impairments in these additional areas of functioning can determine whether an individual with physical or mental disorders remains in an independent community setting or whether he or she must be admitted to an institutional long-term care setting.

The final common pathway to the institution for mentally and physically impaired elderly is decreased capacity for self-care. Inability to manage their own bodily functions or to run an independent household leads to institutionalization unless an institutional environment can be manufactured in the individual's home, with family or paid personnel providing needed services.

Providers of care need to be instructed in techniques allowing them to assess and deal with these multiple factors, which determine whether the chronically impaired elderly patient can remain autonomous. Functional assessment of patients as well as the more familiar diagnostic labeling must be emphasized, assessment that provides a means of demonstrating both an individual's strengths and weaknesses and that can be expressed in appropriate units to indicate meaningful change. Sometimes small shifts can be very important (e.g., regaining the use of an opposing thumb). Expressing change in terms of function allows the pooling of a variety of impacts and should foster collaboration across disciplines.

Impairments in self-care are not necessarily permanent. Adequate assessment and evaluation for rehabilitation potential and skills training may help restore a number of elderly individuals to greater functional capacity and the ability to live independently or with minimal community support. And more emphasis on functional performance for persons admitted to institutional settings may lessen dependency and further augment functional capacity.

E. Individual health needs vary greatly, but recognized demographic variables, including age, sex, race, income, location, family status, and living arrangements can at least partially help in predicting them.

Age is a major factor influencing entry into a nursing home. In 1977, the median age of all nursing home residents was 81.[25] In the same year, only 1.5 percent of those age 65 to 74 were in nursing homes, but 6.8 percent of those age 75 to 84 and 21.6 percent of those age 85 and over were in nursing homes.[26]

Sex has now replaced race as the major single factor influencing life expectancy. For example, a nonwhite woman, age 65 to 70 can expect to live four years longer than a white man, while a nonwhite female infant, born in the U.S. in 1978, can expect to live three years longer than a white male infant.[27] For those blacks and whites who survive to age 70 or 75, the traditional differential in life expectancy has been completely reversed. A black woman of 85 can anticipate 9.9 additional years, 3.2 more than the white woman can.

This does not mean that blacks and other nonwhites now need less health care than their white cohorts. In terms of self-assessment of health status, as late as 1975, twice as many nonwhites as whites rated their health as "poor." (Even among nonwhites, however, 56 percent reported themselves in "excellent" or "good" health.[28]) But it does suggest that the traditional differential is disappearing and, with it, the sometimes alleged need for two separate health care systems. Blacks are significantly under-represented in the nursing home population.[29] It is not clear whether this means discrimination on the part of some homes, more effective family and community supports, or a combination of these.

The proportion of the elderly who consider themselves in good health rises significantly with rising income. For example, nearly 80 percent of those with incomes of $15,000 or more in 1975 said that they were in "excellent" health, compared to only 62 percent of those with incomes under $5,000. Conversely, 12.2 percent of those with incomes under $5,000 said they were in poor health, compared to less than 6 percent of those with incomes over $15,000.[30]

Regional differences are also significant. More of the elderly in the West claim to be in excellent health than those in other parts of the country. The proportion reporting themselves in poor health is twice as great in the South as in the Northeast

Marital status and living arrangements are among the most important determinants of health needs. Of the noninstitutionalized men over age 65 in 1978, 78 percent were married, and an almost equal number were still heads of their families.[31] Only 18 percent were living alone or with nonrelatives. By contrast, only 39 percent of elderly women were married, and 43 percent were living alone or with nonrelatives. Altogether about one-third of all older persons live alone or with nonrelatives. In 1978 about 5.7 million of these "singles" were women: 1.6 million were men. The proportion of singles has been steadily increasing over recent years and, of course, increases with advancing age.

The relationship between marital status and institutionalization is marked. A 1973-74 nursing home survey revealed that only 12 percent of the residents were married.[32] The situation at mental health facilities is equally extreme. Married persons have consistently come under psychiatric care at the lowest rate, the separated and divorced at the highest, and the single and widowed somewhere in between.[33]

There will, almost certainly, be further increases in the proportion of the nonmarried among the elderly. Along with the "graying of America," another demographic revolution has been taking place in recent years: The "singling" or "uncoupling" of America, which results not only from the ever-growing disparity in life expectancy between men and women but also from the decline of the nuclear family.[34] Between 1970 and 1978, the number of men living alone rose by nearly 80 percent; the number of women living alone, by 42 percent. Clearly a rapidly growing proportion of old people will face old age either alone or sharing a home with unrelated individuals. This, in turn, is likely to increase the need for health care and health-related support services.[35]

F. Major portions of the health care systems in the United States are oriented toward acute illness and the practice of specialty and subspecialty medicine. While these elements are highly developed and may meet some of the health care needs of the elderly, the basic approach does not respond to the regularly expected health care experience of the old. The elderly lack primary medical care. Individuals requiring multiple types of health care services often find such services disarticulated and in separate sections of their communities. Continuity of care is difficult to achieve.

Whereas younger patients with acute illness can find health care providers interested in their problems, elderly patients with their complex health, mental health, social, and economic problems encounter substantial difficulty locating health care providers with the requisite attitudes, interests, knowledge, and skills.

In light of demographic forecasts, we will require half again as many health care providers by the year 2010 as we have today just to keep pace with the growing numbers of persons over age 65. When we consider that the bulk of this population increase will occur among those 75 years of age and older—those most likely to contain the vulnerable elderly—the need for additional manpower grows still more. And if we seek not the same, but improved care for our future selves, then the needs projected must be greater still.

Although specific estimates of personnel necessary to provide adequate health care in the future are hazardous, we may safely posit a few principles. Such care will depend upon adequate numbers of appropriately trained and motivated persons and a reimbursement system that encourages (or at least does not discourage) care appropriate to the needs of the elderly patient and the health of that population. Improved health for the elderly will probably mean a delay in marked morbidity rather than an increase in life expectancy.[36]

Geriatric Medicine

Elderly patients often complain, sometimes bitterly, sometimes more plaintively, that they have difficulty finding physicians who are interested and specifically trained to care for older persons. This is especially true where older persons have moved into new communities and must make new connections with primary-care or specialty physicians.

The American Medical Association surveyed over 363,000 physicians in 1977, and only 629 (0.2 percent) identified themselves in any way with geriatric care.[37] Other studies indicate that physicians display a consistent pattern of minimal care to nursing home patients.[38-41] The time they spend with their patients per visit decreases with the age of the patient, whether the visit occurs in the office or in the hospital, and regardless of the type of visit or the complexity of the case.[42]

The reasons for this surprising finding are complex but include: (1) the entire society's negative attitudes toward the elderly, attitudes that physicians and other health care personnel share (what Butler calls "ageism;[43] (2) a lack of specialized training in health care curricula; (3) a recognition of the extraordinary complexity of providing integrated health, mental health, social, and supportive care for older persons; and (4) the concern (often justified) that the health care provider must render services at a loss because older persons frequently lack personal resources to pay for health care costs, and health insurance programs provide only partial reimbursement.

Consensus grows that more and better-trained physicians will be necessary to meet the needs of the aged. There is less agreement about how these needs ought to be met. One school of thought, represented in the Institute of Medicine report,[44] advocates retaining the current heavy reliance on existing physician types (especially primary-care providers in internal medicine, general practice, and family practice). Preparing the physicians for the growing demands of elderly patients would include both more intensive training during medical school and postgraduate years and remedial education through continuing medical education for those already in practice. A cadre of academic geriatricians would be required to accomplish these training tasks, but their sphere of practice would be confined to the academic medical centers. An alternative formulation calls for developing trained geriatricians who can perform both an academic and a practice role.[45] Those geriatricians would serve as consultant specialists to help manage complex geriatric cases while they also maintained responsibility for some subset of geriatric patients requiring their care. A third approach to the problem has been to identify

where geriatric physicians would focus their activities and thereby estimate the need for them.[46] Such estimates strongly emphasize the nursing home and the teaching hospital.

There is consensus about several points: (1) additional manpower is required; (2) at a minimum, a corps of academically oriented geriatricians is necessary; and (3) the primary-care physician must have skills and motivation beyond those currently shown. At a time when the Graduate Medical Education National Advisory Committee (GMENAC) has predicted a surfeit by 1990 of physicians in virtually all areas, including primary care, these critical elements should be borne in mind.[47] It is now more appropriate to talk about redirecting physician manpower into the care of the aged than to speak of curtailing it.

Drawing upon the data collected as part of a national study of physicians conducted by the University of Southern California's Division of research in Medical Education (USC/DRME), we estimate that, in 1977, approximately 187 million physician visits were made by individuals aged 65 and older (including 84 million made by those aged 75 and older).[48] By the year 2030, we anticipate that demographic pressure alone will occasion 443 and 221 million annual visits, respectively.

The Rand Corporation has made quantitative estimates of what various configurations of geriatric physician manpower imply.[49] When one applies these projections to population estimates for 1977 and for representative years in the future, one senses the numbers of personnel the various configurations require. Table 3 provides such data for the years 1977 and 2010. As the table reflects, the burden of physician manpower required for the model continues to rest with the primary-care physician if current distribution (status quo) remains the same and if the geriatrician still operates in the consultative mode. As the geriatrician takes on increasing primary-care responsibilities, the burden of care is more equally shared between the geriatrician and the primary-care physician. All of the projections here assume that we would be offering care at current levels of use. Our estimates suggest that, if we want to provide care equivalent to that provided for other sectors of our society, a shortfall of approximately 25 percent now exists.

Defining the onset of old age as beginning at 75 instead of 65 may provide a more appropriate target for geriatric care than we now have. As shown in Table 4, the numbers of physicians required are somewhat reduced, commensurate with the smaller population to be served. However, because persons over 75 use substantially more care than do those over 65, the numbers re-

main large. Geriatric nurse practitioners/physician assistants and social workers can help serve those numbers and share the medical care burden of the elderly. Substantial delegation (up to 50 percent of outpatient care) is possible, but delegation like that portrayed in Table 5 does not produce a commensurate reduction in the level of physician manpower necessary. The productivity levels of the nonphysician providers are there estimated to be only about 60 percent of that of physicians.

Table 3
Number of Physician Personnel (in FTEs) Needed in 1977 and 2010 to Care for Persons 65 Years and Older at Current Utilization Levels

	Number of Physician Personnel Required					
	1977			2010		
Mode of Geriatric Practice	GS	MSS	PCP	GS	MSS	PCP
Status quo	432	730	22,772	655	1109	34,453
Consultative	9915	5484	17,808	15,000	8330	26,953
Primary Care	15,000	5484	14,214	23,452	8330	21,527

NOTE: GS = geriatric specialist.
MSS = medical subspecialist.
PCP = primary care physician (i.e., general internist, family physician, and general practitioner).

Table 4
Number of Physicians (in FTEs) Needed in 2010 to Care for Persons 75 Years and Older at Current Utilization Levels

	Number of Physicians Required		
Mode of Geriatric Practice	Geriatric Specialist	Medical Subspecialist	Primary Care Physician
Status quo	335	577	17,441
Consultative	7587	4357	13,688
Primary care	11,823	4357	10,987

Table 5
Number of Physician and Nonphysician Personnel (in FTEs) Needed in 2010 to Care for Persons 65 Years and Older at Current Utilization Levels Under Two Levels of Delegation

Mode of Geriatric Practice	Number of Physician and Nonphysician Personnel Required									
	Moderate Delegation					Maximal Delegation				
	GS	MS	PCP	GNP/PA	SW	GS	MS	PCP	GNP/PA	SW
Status quo	520	1,109	26,914	11,622	3,766	391	1,109	19,852	19,479	7,532
Consultative	11,702	8,330	21,156	12,169	3,941	8,618	8,330	15,692	20,398	7,882
Primary care	18,205	8,330	17,026	12,169	3,941	13,329	8,330	12,739	20,398	7,882

NOTE: GS = geriatric specialist.
MSS = medical subspecialist.
PCP = primary care physician (i.e., general internist, family physician, general practitioner).
GNP/PA = geriatric nurse practitioner or physician assistant.
SW = social worker.

We emphasize that the effects of our proposed changes would be to redistribute physician workload. No new physician manpower is required beyond that already projected by GMENAC. In fact, the redistribution we envision would alleviate some of the problems GMENAC has predicted. The general sense of our proposal is shown in Figure 5. We anticipate a growth in the total need for services between 1980 and the year 2000 due to the growth in the elderly population. Adding a corps of geriatricians would reduce the geriatric workload of primary-care physicians and specialists: but because the geriatricians would come from this pool of physicians, no overall shift in the numbers of physicians is required.

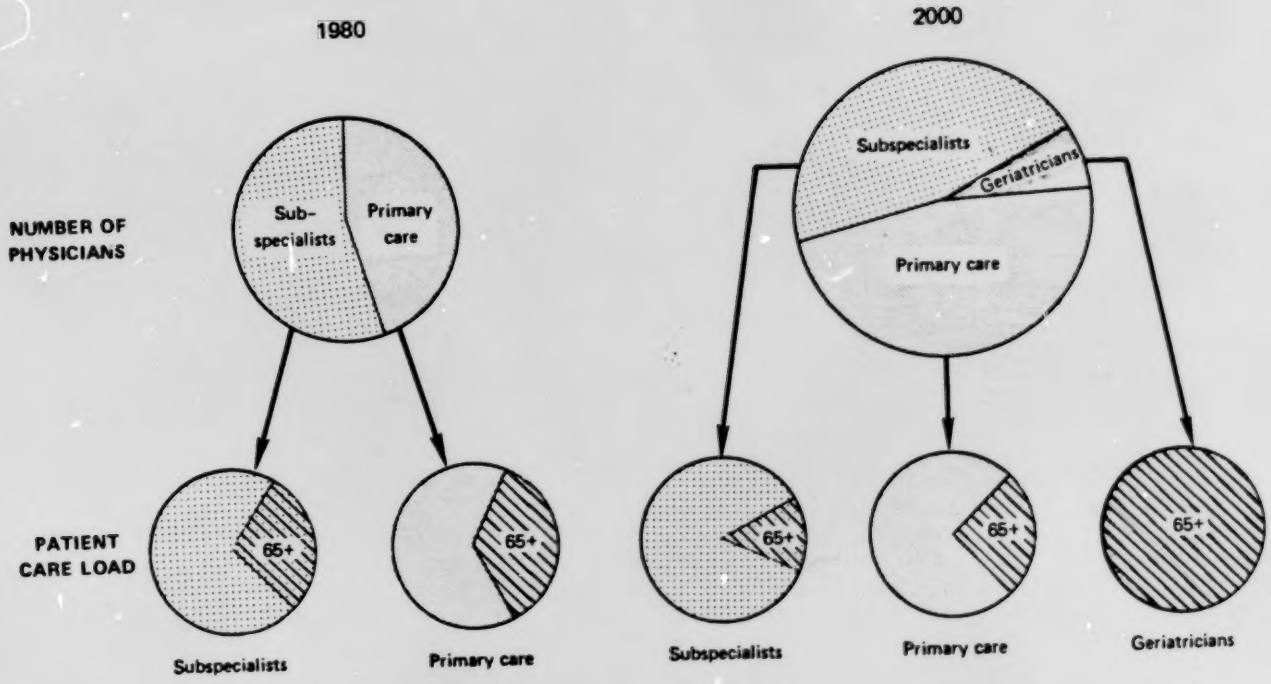

Figure 5: Effects of Proposed Redistribution of Physician Manpower to Include Geriatrics

The arrangements presented in the table represent admittedly arbitrary proportionate distributions of effort and should be taken as only indicative points along a more continuous spectrum. Nonetheless, several conclusions emerge:

1. Substantial numbers of physicians skilled in providing care for the elderly are needed.

2. If a large proportion of those physicians are to be trained geriatricians, the programs to meet this manpower demand must be started at once.

3. The most conservative estimates suggest a deficit in geriatric manpower; training programs now underway yield far less than 100 graduates each year.

4. Even if we take the most extreme model, which calls for the geriatrician to deliver primary care, primary-care physicians and medical subspecialists will still have substantial responsibility for care of the aged. Training programs to prepare these physicians adequately require immediate attention.

5. If we are to rely on nonphysician providers for any proportion of the care for the elderly, similar programs must be developed at once to train such professionals.

6. A large proportion of the mental health needs of the elderly can and will be met by providers other than geropsychiatrists. These personnel include: general psychiatrists, geriatricians, primary-care physicians, other primary-care providers, and other nonphysician mental health personnel.

7. There is also a shortage of physicians trained in physical medicine and rehabilitation, skills sorely needed by the elderly. Because basic medical education provides little training in this field, geriatric training will have to cover this important area.

Thus, regardless of the final model chosen, the need immediately exists for a substantial cohort of academically based geriatricians to educate the future generations of physicians and nonphysicians who will care for the elderly. Using rather conservative criteria, we estimate an immediate need for 900 to 1600 full-time academic geriatricians to serve as faculty for medical school and graduate training programs in internal medicine and family practice.

Nursing

The general shortage of active nurses is exacerbated in the case of the elderly. Current estimates predict a shortfall of at least 75,000 nurses just to staff nursing homes. Data on other modes of care for the elderly are less complete, but the picture looks equally bleak. Geriatric nursing currently confronts two major obstacles: (1) inadequate training for nurses in geriatrics and gerontology, and (2) a salary differential biased in favor of hospitals and against long-term care institutions, especially nursing homes. This bias is especially unfortunate now when positive incentives are needed to attract nurses to care for the elderly.

The situation is much the same with the paraprofessionals in nursing. Aides in nursing home jobs tend to be less well trained than those in better paying hospital jobs. Too often nursing home aides come from the lowest socio-economic strata (often new immigrants) and consequently face problems of illiteracy and of differences in language and culture, with all the attendant social problems those handicaps raise. Turnover rates among this group range from 75 percent per year to five complete changes per year—a 500 percent turnover rate. Nurse extenders comprise almost two-thirds of the nursing home employees providing health care services to residents.

Several strategies have been proposed to deal with these serious problems of quantity and quality. One approach favors increasing the involvement of professional nurses. Proponents derive this approach from hospital experience and call for more direct care by professional nurses, who would assume a primary relationship with a group of patients. This would reverse the current proportionate distribution of nursing personnel, which features as many as six or seven paraprofessionals for each nurse. Experience in hospitals that have converted to primary nursing suggest that it results in improved quality of care and may even save money by reducing the turnover and improving efficiency.[50]

The other major approach emphasizes downward delegation of care; lesser trained personnel provide more rather than less care. Geriatric nurse practitioners may assume primary care roles that physicians usually fill, and nurses may serve as supervisors of LPNs and aides. Such a strategy clearly relies on improving the number and quality of aides. Critical steps toward this goal include improved pay above the minimal wage to attract more qualified personnel, longer and better training in the care of the elderly through both preparatory and in-service programs, and more opportunities for career mobility.

Such mobility may be enhanced by replacing the vertically mobile career ladder by which an individual rises through the nursing ranks with a career lattice in which an individual moves horizontally to gain skills in a variety of specialty areas serving different type of patients and thus avoiding boredom and frustration. However, little information is yet available to assess the effectiveness of this lattice approach. Many are skeptical because the large amount of money already invested in in-service training has not yielded many dividends.

Advocates of downward delegation argue that family and friends, not professionals, usually perform the majority of tasks involved in caring for the elderly. Increasing the professional participation in such care, then, may be at best

wasteful and at worst harmful if health values are allowed to dominate social issues. At this time not enough evidence exists to favor either side entirely. But there is consensus that more and better nursing care is sorely needed. The next appropriate steps, therefore, include increasing the gerontological content in nursing education and altering practice regulations to facilitate more extensive use of nurse clinicians and nurse practitioners. This alteration would allow them to function without on-site supervision and with the authority to prescribe drugs and other services (e.g., home care, rehabilitation).

Whatever the strategy adopted to augment nursing services to the elderly, it must come at an increased cost. Both the unit costs resulting from restoring salary equity between hospital and long-term care system and the aggregate costs will increase as more nurses enter the service of the elderly.

Other Health Professions

A number of other professions can potentially benefit the health of the elderly. The difficulty to be resolved is how we might allocate resources to best use these services. Each profession offers at least some evidence to suggest the benefits of their services, but we lack information about precisely how much and what kind of improvements might result. Without such information, it is extremely difficult to argue strongly for including one program and not another. Yet it seems increasingly less likely that we can affect them all.

Table 6 summarizes the current and expected supply of personnel for several of these professions. Unfortunately the quality of data available for many of these professions is not adequate to make clear statements about either supply or demand. In almost no instance has there been any specific effort to project the manpower needs for the elderly. In the cases of dentistry, pharmacy, and optometry, anticipated supply overall should be sufficient to meet the needs of the general population over the next decade, although almost no data refer specifically to the elderly. The barriers to more extensive use rise from the current restrictions in third-party coverage, which exclude payment for most, if not all, of their services. Virtually all the professions shown in Table 6 point to Medicare's failure (usually in Part B) to provide coverage as a major impediment to their greater participation in caring for the aged. In some areas, the current and projected elderly clientele have already prompted educational reforms. Curricular components covering gerontologic topics have been launched in several professions, including pharmacy, occupational therapy, and podiatrics, but they are not yet universally incorporated.

Table 6
Projected Personnel Supply and Requirements for Various Professions—1980 and 1990
(in 1000's)

Profession	Projected 1980 Supply	Projected 1990 Supply	Projected 1990 Requirement	Services to the Aged
Dentistry	126.2	154.5	147.6	Not covered by Medicare 50% of population over age 65 edentulous
Pharmacy	142.6	184.8	158.7	Drugs and pharmacist services not covered by Medicare Polypharmacy, compliance difficulties
Optometry	22.2	26.5	26.0	Not covered by Medicare
Podiatry	8.9	12.5	16.1	Over 1/3 of visits by the aged not covered by Medicare
Audiology	4.8	7.0 (1985)	19.9 (1985)	Only audiology testing covered by Medicare
Speech Pathology	37.3	53.9 (1985)	71.9 (1985)	Approximately 20% work with the aged Not covered by Medicare
Physical Therapy	30.0	NOT AVAILABLE		
Occupational Therapy	17.5	32.0	37.5	By 1990, 25% of OTs will be working with the aged 23% of budgeted positions in nursing homes vacant

Although not really a health profession, social work relates closely to health services for a substantial number of its members. Some indication of the extent of involvement can be gleaned from information available, despite the scarcity of good data. For instance, in a 1974 poll of over 80,000 members of the National Association of Social Workers (including both masters and bachelors level), over 30 percent of the 35,000 respondents indicated health or mental health as an area of specialty, although only 2.5 percent claimed aging as their primary practice field. About half of the over 7,000 hospitals in the country have social work departments (ranging in staff size from one person to over 100 people), and most of the clients for these departments are elderly. Although schools of social work show no consistent pattern of mandated curricula in aging, some signs of increased attention to this area have appeared. Because the numbers and types of persons working in social welfare vary, any clear estimate of future needs is difficult to reach. But there is a sense that not enough social workers have the requisite knowledge, skills, and attitudes to serve current geriatric programs.

G. There is increasing recognition of the need for preventive programs and services, especially with respect to chronic disease and accidents.

Smoking is now widely recognized as the single major preventable cause of death in America.[51] Alcohol abuse is a close second. Falls, malnutrition, excessive or incompatible medications, social isolation, poverty, poor housing—all these common debilitating problems take their tragic toll and require multidisciplinary preventive programs. Two prominent geriatricians make the point clear.

> The greater incidence of falls has been attributed to a number of factors: loss of muscle strength and endurance ability; loss of vision and hearing acuity (for those 75 and over, less than 20 percent have normal vision even after optimal correction); slowed adjustment to light-dark changes; postural imbalance; altered gait and slowed reaction time. These interact with hazards in the physical environment which are quite common despite the obvious risks they entail: low levels of lighting, carpets that slide, objects left on the floor, lack of handrails, and broken pavements. A considerable portion of falls are the first manifestation of the onset of acute disease. Still other falls are due to medication side effects (such as a drop in blood pressure on standing).

> Malnutrition is a dependency factor because it is one of the causes of reversible dementia. Malnutrition may also have a role in the changes in bone structure that so many elderly undergo, but this is far from established. . . . What is clear is that many of the elderly are malnourished. . . . The elderly are also prone to dental problems. About half do not have any natural teeth, and among these edentulous persons, 24 percent do not have false teeth or do not use the teeth they have been fitted with. Economic considerations come into play here too, since utilization of dental services is proportional to ability to pay. Limited physical ability interferes with these other factors in setting up conditions for malnutrition. Elderly persons who cannot shop or cook are in need of social service preventive health programs that circumvent physical restrictions.[52]

Preventive measures, then, can help the elderly avoid common problems. But even when chronic disease is present, "secondary" and "tertiary" prevention —early detection, appropriate medical management, and responsible patient practices—can usually minimize the disease's severity and disabling consequences. For example, controlling high blood pressure can prevent strokes and premature death in the elderly.[53]

Prevention requires good, easily accessible primary care, including a family physician or other primary-care professional, to whom the elderly patient can relate personally and with continuity. Because Medicare does not pay for preventive services (see below), patients may find it almost impossible to locate a doctor willing to see them except when they are clearly ill. Medicare's failure to cover eye examinations for glasses, and routine dental, auditory, and foot care also serves to discourage timely preventive care. "Doctor shopping," unnecessary use of often duplicative specialty services, self-medication, resorting to quacks and ineffective drugs are all part of the price frequently paid for the absence of a reliable, continuing, doctor-patient relationship. The nation clearly follows a "penny-wise, pound-foolish" policy with respect to health maintenance for the elderly and pays a high price for it in terms of both preventable health problems and higher costs.

H. For the dying patient, humane terminal care is often the most pressing need, and it is usually difficult to meet.

Fifty years ago most deaths occurred at home, with relatives and friends gathered around the death bed to hear the dying person's last words. Death was part of life. But today some 70 percent of deaths in this country take place in a hospital or other institution where care is often impersonal, and the dying

may feel forsaken and dehumanized. Patients who have no chance of recovery are subjected to useless, expensive, and often painful procedures chiefly because, to most physicians, death is viewed as "an enemy to be held at bay as long as possible. Professionally committed to saving lives and equipped with elaborate medical technology, doctors—and many nurses, too—have regarded death as the ultimate failure".[54]

The first "death with dignity" law was passed in California in 1976; since then, nine additional state legislatures have adopted similar statutes.[55] Others are under consideration in all but two states. The New Jersey Supreme Court, in the famous Quinlan case, ruled that a patient's right to die is in accordance with the "right to privacy".[56] Concern for Dying, an organization that now claims over 300,000 active financial supporters,[57] has distributed over three million copies of the "Living Will." This document requests that "if there is no reasonable expectation of recovery," the patient be allowed to die and not be kept alive by "artificial means or heroic measures."

Such instructions are not legally binding, and in the frequent absence of a devoted family physician, compliance is doubtful. Moreover, a technical problem compounds the legal and ethical ones: "reasonable expectation of recovery," "heroic measures," and "artificial means" are all open to widely differing interpretation, and applying them to individual cases can be excruciatingly difficult for both doctor and family.[58] There is also a danger opposite to viewing death as an enemy we must defeat. Some doctors, perhaps angered by the accusation of "denying death," have gone to the other extreme, insisting on blunt, even brutal "truth telling," regardless of how it affects patient and family.[59]

The need appears to be three-fold: (1) to permit the dying patient to exercise as much autonomy over his or her own life as possible; (2) to provide some mechanism for responsible and objective decision-making that will permit respect for the patient's wishes while protecting the professionals involved; and (3) to promote the establishment and maintenance of health-care settings such as the new hospice concept, which will permit terminal patients to derive as much satisfaction as possible from their remaining time and finally die as good a death as possible.

I. For most people over age 65, the Medicare experience has been, on the whole, positive. Coverage of acute hospital care is good, of physicians' services, fair. Major deficiencies relate to costs—both to the individual and to society—and to failure to cover preventive and long-term care. This omission has an effect on health and contributes both to the ever-increasing fragmentation of services and to the unacceptable rise in costs. Medicare urgently needs reform.

Medicare provides virtually complete coverage of essential hospital services. The services it omits—private duty nursing, private room unless medically required, television and telephone—are generally considered reasonable, especially in view of the general use of intensive care units for the very ill. However, the amount of cost-sharing has increased rapidly. The first-day deductible is now $204, up from $40 when the program started in 1966. Copayment for the 61st to 90th days is now $51 a day, up from $10 at the start. Copayment for the 60 lifetime reserve days is now $102, up from $20. These increases mean that many patients still receive sizeable hospital bills. In addition, utilization review committees and Professional Standards Review Organizations (PSROs) increasingly scrutinize hospital stays. This is proper from society's point of view but can result in individual hardship, especially if appropriate alternatives to hospital care are not available or are not covered by Medicare. Standards developed with younger patients in mind for length of stay or for services required are often too restrictive for the older patients' complex problems. PSROs may inadvertently deprive the elderly of badly needed care and may prevent the establishment of such innovative care programs as the Geriatric Evaluation Unit.

The net result of these various limitations is that Medicare met only 75 percent of average per capita expenditures for hospital care for the elderly in 1978 (Figure 6).[60] The figure is probably a little lower today. Other public programs—Medicaid, Veterans Administration, state mental hospitals, etc.—help to fill the gap but, as of 1978, 13 percent ($109 per capita) still had to be financed privately. Much of this was done, or at least attempted, through private supplementary insurance of various types. Some of the coverage is useful, but much is wasted. Some states have tried to strengthen their regulation of supplementary insurance. Many experts feel that a new federal "catastrophic" insurance program would simply further inflate hospital costs and end up doing more harm than good. Therefore Medicare needs to include some reasonable limits on cost-sharing for: (1) those few patients who have to remain in the hospital for more than 60 days, and (2) those whose combined deductible and coinsurance come to a substantial figure, say $1000.[61,62]

As the original Medicare law now stands, Section 1862 clearly omits preventive and long-term care, strictly limiting coverage to "diagnosis and treatment of illness or injury to improve the functioning of a malformed body member." The law specifically excludes "routine physical checkups, eyeglasses or eye examinations for the purpose of prescribing, fitting or changing eyeglasses, hearing aides or examinations therefor, or immunizations . . . or orthopedic shoes or other supportive devices for the feet" as well as "custodial care".[63]

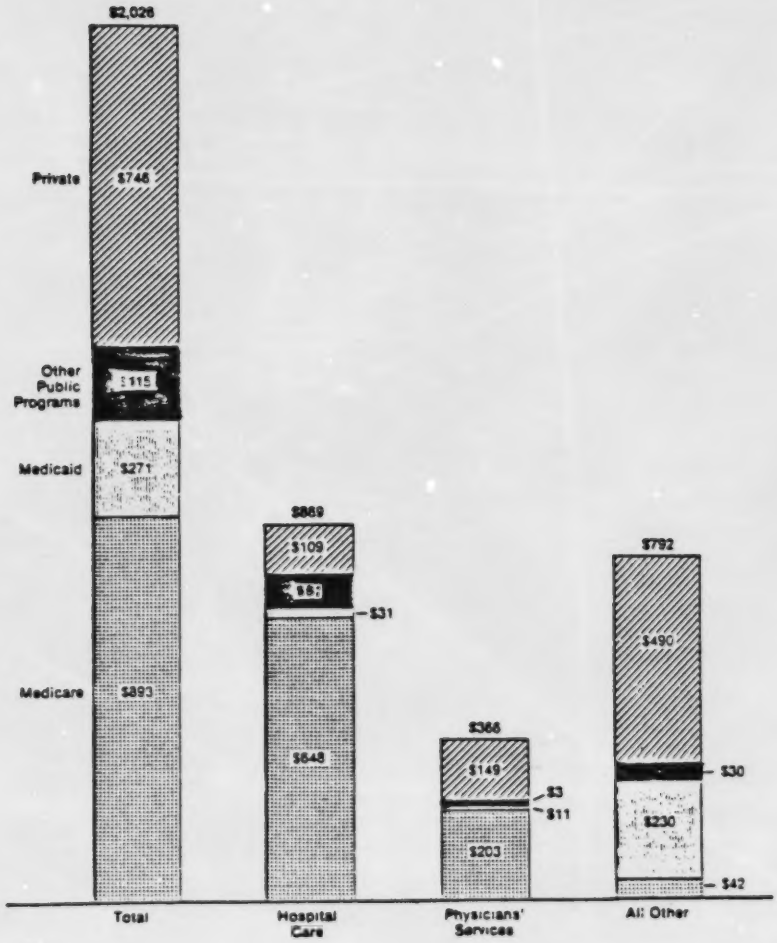

Figure 6: Per Capita Personal Health Care Expenditure for the Aged, by Source of Funds and Type of Care, Calendar Year 1978.

SOURCE: C. R. Fisher "Differences by Age Groups in Health Care Spending" *Health Care Financing Review* 1:65-90, 1980.

Such omissions may or may not have been justified in 1965. We clearly cannot justify them today, whether we consider them in terms of health effectiveness or cost effectiveness. A program offends common sense when it saves $75 by denying an elderly individual eyeglasses but reimburses that individual thousands of dollars after a fall or auto accident caused by poor eyesight. It is sheer folly to deny the arthritic patient $150 for orthopedic shoes but reimburse that patient $5,000 for an operation. It is equally ludicrous to prohibit regular dental hygiene but provide open-ended reimbursement for a digestive disease which may result from poor dentition.

Aside from prohibiting preventive services, Medicare coverage of physicians' services has other problems, problems relating to physician payment:

1. *Physician Participation.* Except for a small handful of doctors whom Medicare has barred for fraud, there is no meaningful distinction between the participating and nonparticipating physician. Every physician has a choice between accepting "assignment"—direct billing to and payment by the Medicare carrier—or billing the patient, who then bills the carrier. In the latter case, the doctor can charge whatever he wishes, but Medicare will reimburse the patient only 80 percent of what it defines as the "reasonable charge" (see below). Moreover, the doctor is free to pick and choose among his patients, deciding which method he prefers in each case. Some physicians, especially in affluent communities, never accept assignment. Over the years, assignment rates have been declining, and the net assignment rate (excluding claims from hospital-based physicians and group practice prepayment plans) appears to have stabilized at about 51 percent.[64]

2. *"Customary, prevailing, and reasonable (CPR) charges."* Even doctors who accept assignment do not have to agree to accept specified fees. The Medicare law provides payment for doctors on the basis of their own "reasonable charges." This blank check approach may have been justified when most doctors adjusted their bills on the basis of the patient's ability to pay and did a fair amount of free care. Today, with payment guaranteed for all Medicare beneficiaries, it is clearly inappropriate. In the effort to apply some limits to the "blank check," Congress and the Department of Health and Human Services have established a number of regulations, defining the "reasonable charges" concept without repealing it. The result is a maze of confusing regulations, generally known as CPR. According to the official Medicare patient reimbursement form (32907 Ed. 7-79), the amount that Medicare will pay the doctor or will reimburse the patient is limited to the lower of two factors: (a) the doctor's customary charge (i.e., the charge made

in 50 percent of the billings during the base year); or (b) the prevailing charge (i.e., the charge made 75 percent of the time by other physicians in the area for similar services during the base year).

Despite the formula's complexity, it has at least two clear implications:

(a) It is highly inflationary. The so-called limits do little more than put the Department's stamp of approval on unilaterally determined fee increases. The dramatic rise in physicians' fees throughout the Medicare years testifies to this.

(b) In the largely futile effort to stem the rise of fees, regulations have become both more complex and more onerous. Today neither patient nor physician generally understand them. Disallowances are increasing—the 1979 average charge reduction rate was 21 percent[65]—and the confused patient suffers financially, receiving 80 percent of a figure not known in advance. Moreover, there is no way to insure against excessive charge. The various "Medigap" or private supplementary policies already noted limit their liability to 20 percent of the allowed charge, not the total charge.

These shortcomings, both in coverage and method of payment, mean that Medicare accounts for only 55 percent of per capita physician expenditures for the elderly:[66] and the 45 percent to be paid by the individual is added to the cost of Part B premiums or other health insurance. According to one study, the combination of Part B premiums, deductibles, coinsurance, and "excess" charges rose more than 23-fold from $50 million in 1968 to over $1.1 billion in 1979.[67] The difference in charges to Medicare patients among doctors, even in the same locality, has also become extreme. The same study showed some physicians in Washington, D.C., charging two to five times as much as others in the same city. The situation has become untenable for all parties: patients, physicians, and government. The need for basic change in the law is undeniable.

The biggest and most financially devastating gap in Medicare coverage is in the area of long-term care. In 1977, almost 15 percent of the noninstitutionalized elderly suffered some degree of activity limitation. In fact, 15 percent of those age 75 to 84 and 32 percent of those over age 85 were too disabled to carry out their major activity. Furthermore, 1.4 million disabled adults live alone and do not receive care.[68] As already noted, approximately 5 percent of the elderly population is institutionalized, most in nursing homes. About 10 percent need long-term home support services.[69,70] Altogether, it appears that

we are talking about some 15 percent of the elderly, or 3.8 million individuals, in various stages of severe or progressive disablement. With the anticipated increase in the "old-old" category of persons over age 65, the proportion of disabled and dependent elderly may also be expected to rise unless serious corrective action is undertaken. And such action should be directed squarely at helping disabled elderly persons maintain maximum functional independence and quality of life.

Although more persons in the community than in institutions require assistance with daily living activities,[71] Medicare has explicitly rejected as hopeless "custodial" patients struggling to increase or maintain functional independence. The official *Medicare Handbook,* distributed to all beneficiaries, instructs them as follows:

> Care is considered custodial when it is primarily for the purpose of meeting personal needs and could be provided by persons without professional skills or training; for example, help in walking, getting in and out of bed, bathing, dressing, eating, and taking medicine. Even if you are in a participating hospital or skilled nursing facility or you are receiving care from a participating home health agency, Medicare does not cover your care if it is mainly custodial.[72]

This statement is tantamount to saying that public policy aims at discouraging the disabled elderly from making any effort to get out of bed, walk, or otherwise make themselves independent. A more destructive health-care policy—either in terms of health outcomes or costs—would be difficult to design.

Another difficult and currently insoluble problem in the long-term care field is the extent to which elderly patients are receiving inappropriate care, e.g., are kept in acute care hospitals when a nursing home would be more suitable or in nursing homes when home care or boarding homes would be more desirable. A 1979 study by the Comptroller General cites studies showing that 10 to 40 percent of the elderly population living in nursing homes could live in the community if appropriate support services were available.[73] The study concluded that the elderly who make up 86 percent of the nursing home population neither needed nor wanted such care. Even patients with chronic conditions resulting in substantial functional limitations could avoid institutionalization if appropriate living arrangements and caring spouse or children were available to them.[74]

Part of the problem comes from criteria from nursing home admission and discharge, whch are notoriously imprecise and subjective. For example, a major factor leading to admission is incontinence or even the fear of incontinence on the part of the patient's family. Unfortunately, the institutional milieu can often promote rather than help the condition. Lack of adequate nursing personnel and the inability of aphasic or demented patients to communicate can result in incontinence, even where it had not been evident prior to institutionalization.

Today Medicare has shown some sign of changing policy, at least with respect to home care. From the beginning, Medicare Part B has paid for up to 100 home health visits per year, regardless of prior hospitalization, if a physician orders the care. This home health care, which a participating home health agency provides, includes part-time skilled nursing and physical or speech therapy. However, the use of such services has been minimal for many reasons, including physicians' lack of interest and unavailability of home health personnel. In turn, these conditions are due, at least in part, to the low priority that Medicare assigned this benefit.

The tremendous rise in institutional costs plus the rapidly growing interest in geriatrics and gerontology, and a more enlightened view of long-term care generally have led to increased pressure on Medicare to open up its benefits in this area. As part of a number of Medicare/Medicaid amendments which became law in December 1980, the home health benefit has been substantially liberalized by: (1) providing for unlimited visits; (2) eliminating the present three-day prior hospitalization requirement for visits under Part A; (3) adding occupational therapy as one of the qualifying criteria; and (4) permitting proprietary home health agencies to qualify. The current $100 limit on outpatient physical therapy will also be raised to $500.[75]

The growing interest in home care does not mean that the need for institutional long-term care does not exist today. On the contrary, because of the average inpatient age of 81, the many seriously ill or disabled patients, the shrinking family, and the absence of adequate community health and social supports, the nursing home is obviously here to stay. And it may well be that we should have more, not less, nursing home beds per capita. We need a reimbursement system unlike what we now have, one that does not favor any one kind of care—hospital, nursing home, home care, or community-based services —over another. Instead, it should allow physician, patient, and family to choose among these modalities on the basis of cost- and health-effectiveness.

Furthermore, our present system is unconscionably expensive, both to the individual and to society. Per capita expenditure for nursing home care in 1978 was $518—25 percent of total health care expenditures for those over age 65.[76] The beneficiaries financed about 52 percent of all nursing home care from their own pockets in 1978.[77] For those who do go to a nursing home, the cost is often devastating—and not only in dollars and cents. A recent study of nursing homes notes:

> Many individuals who enter nursing homes as "private" patients soon acquire Medicaid eligibility through what is known as the "spend-down." In many states, Medicaid coverage is available for nursing home care for all those for whom the costs of care exceed income once assets (above a nominal level generally in the range of $1,000 to $3,000) have been liquidated. Essentially, Medicaid requires nursing home residents to exhaust their life's savings before qualifying for public assistance. (Given the cost of nursing homes and the limited assets of most American families, that process can take place very rapidly.) Under Medicaid, children are not financially responsible for the care of their parents (a phenomenon that has helped give rise to the mythology of family "dumping" of the elderly) but spouses are; hence, the phenomenon of couples married fifty years divorcing to enable one of them to get nursing home subsidy without totally impoverishing the other.
>
> The spend-down for nursing home care presents many middle-class families with an excruciating dilemma. Either they violate the law by covertly attempting to transfer the parent's assets before admission to a nursing home (possession of a single savings account accumulated through years of frugality and hard work can cause disqualification) or they can watch passively as an inheritance goes up in smoke. For those families unwilling or unable to transfer assets covertly, nursing home services have thus become the most effective barrier to intergenerational transfer of income ever seen in this country.[78]

Many nursing homes now require large down payments, sometimes representing charges for a year or more. Once paid, such down payments can make the patient a virtual hostage. Or, if originally admitted on a self-pay basis, the patient may have to leave when all private funds are consumed and Medicaid must assume responsibility.

From the nursing home operator's point of view, there may be justified fears that the state will alter Medicaid payments without notice and that the payments may be too low to permit operation of a quality home. Despite all the

indignities and other problems associated with Medicaid today, however, that program pays a large portion of the nation's nursing home bill, estimated at nearly $22 billion in 1980.[79] In 1980, Medicaid spent $8.4 billion on long-term care services, of which 98 percent went to nursing homes.[80]

Payments for drugs and prophylactic dental services must also be paid out of pocket unless the patient is institutionalized. The number of prescriptions per capita for the elderly averaged 14.4 in 1973, at an average price of $5.09. Both figures have risen substantially since then. The average cost of prescription drugs and dental services to the elderly person in 1978 is estimated at $160.[81] The elderly also have to pay their share of Part B Medicare premiums, now $9.60 a month, or $115.20 a year, and in 1977 they also paid an average of $90 a year for supplementary private insurance.

Altogether, the average per capita health bill for the elderly reached $2,026 in 1978, of which the elderly themselves paid $746, or 37 percent; the balance was paid through tax-supported programs (see Figure 6). Medicare itself paid for only 44 percent. The figure would be smaller—about 41 percent—if the costs of Part B premiums were counted as health care costs as they are today by Congress's Select Committee on Aging, the Internal Revenue Service, and most health authorities.[82,83]

Despite the effort to hold down Medicare costs by substantial cost-sharing for hospital services and by refusal to cover preventive and long-term care services, the costs of the program have continued to mount astronomically. Medicare has contributed greatly to increased admissions for the elderly and to an increased rate of surgery. From 1965 to 1972, hospital discharges with surgery rose at an annual rate of 1.8 percent; from 1972 to 1976, 2.9 percent.[84] Between 1971 and 1977, while total physician visits did not change significantly, inpatient visits and surgical services as a proportion of total visits increased, leading to a shift in physicians' charges toward more expensive types of care.[85]

Total Medicare costs (benefits plus administration) came to $25.5 billion in FY 1979 and an estimated $30.6 billion in 1980.[86] This may be compared with a total of $7.1 billion in 1970. The average annual rate of increase over the decade was 15.6 percent, and it is estimated to rise 19.1 percent between 1979 and 1980.

Moreover, the health costs for the elderly that Medicare has not met often fall on other tax-supported programs such as Medicaid, state mental hospitals, the VA hospitals, and workmen's compensation programs. In 1978, for example,

over 19 percent of the per capita health costs of the elderly were met through other tax-supported programs.[87] Indeed, over half of all public spending for health in 1978 was for the elderly, although they represented only 11 percent of the population.[88]

From a financial perspective, then, Medicare has to be faulted on all scores: (1) except for acute hospital care, it has fallen far short of the implied promise to individual beneficiaries; (2) it has met such a small proportion of the elderly health care bill that other tax-supported programs have had to fill in by nearly 20 percent; and (3) it has contributed substantially to the general inflation in health care costs and the defeat or postponement of national health insurance.

The general picture that emerges from this whole discussion is that of a program that no longer fits the new patterns of morbidity and mortality among the elderly. Medicare pays too much for the most expensive forms of care and too little or nothing for the less expensive forms of care (e.g., prevention and long-term care). It helps fragment care rather than unify it. It therefore basically undermines the primary health goal of most older Americans today: to improve the quality of their lives and maintain maximum functional independence. Medicare's failures certainly do not mean that it should be scrapped. The program does, however, need substantial reform.

J. Just as the health experiences of the elderly differ from those of the young, so do the health experiences of the minority elderly, especially of black, Hispanic, or American Indian elderly, differ from those of the majority elderly. Certain elements of the health care system meet their needs even less well than they do those of majority elderly. Thus, some minority elderly will experience age-related health problems and may, in fact, die before attaining the age at which they become eligible for Medicare. In addition, many more minority elderly do not have Medicare and/or Social Security benefits available to them at age 65 due to low earnings during their working years. Limited availability of health care personnel sensitive to language requirements, customs, and social needs of ethnic minorities compounds the problems.

For statistical purposes, four minority groups are usually designated in the United States: black Americans, Hispanics, Pacific Asians, and American Indians-Alaskan natives. Within these groups, distinct subgroups exist. For example, Hispanics include the Spanish of European origin as well as Mexicans, Puerto Ricans, Cubans, and those from Central and South America. The American Indians and Alaskan natives include such diverse populations as

Eskimos, Navajos, and the Cherokees of North Carolina. These minorities make up a sizeable portion of the non-institutionalized elderly population over age 65 in the United States. The population is composed of 22,300,000 whites, 2,040,000 blacks, 1,100,000 Hispanics, and 100,000 Pacific-Asians. There were 83,000 American Indians over the age of 60 as of June 1978.[89]

Studies on health differences between older whites and minorities reveal that older minorities suffer poorer health than do older whites.[90-93] Minority elderly suffer a higher prevalence of chronic disease; older blacks are especially vulnerable to hypertension and heart disease.[94] Furthermore, minorities experience 50 percent more days of bed disability yearly than do whites[95] and considerably higher numbers of restricted activity days and bed disability days than do other older persons.[96]

Not surprisingly, the minority elderly's report on their own health status reflect higher morbidity and mortality rates than do the majority of elderly reports. We noted earlier that a DHEW study found that minorities were 60 percent more likely than whites to judge their health as only fair or poor.[97] In a 1974 Los Angeles County health survey of 247 respondents in the 65 to 74 age group, 65 percent of the blacks, 62 percent of the Mexican-Americans, and 38 percent of the whites reported poor or fair health.[98]

Although, as we pointed out in an earlier section, sex is a more important factor than race in determining longevity, minority elderly are still at a disadvantage compared to whites; but the gap is closing. Minorities at age 60 have fewer years to remaining life expectancy (17.9) than do whites (19.0) and a smaller percentage of ethnic minorities live to be 60 (70 percent as compared to 83 percent of whites).[99] In other words, more minority elderly per 100,000 population die than do their white peers.[100]

Besides these manifest differences between majority and minority, the minorities differ even among themselves. For instance, American Indians and Alaskan natives are at particulary high risk of obesity, several types of cardiovascular and cerebrovascular diseases, gall bladder disease, diabetes, cataracts and other problems affecting vision. Rheumatoid arthritis may be greater among older Indians than among the U.S. elderly as a whole:[101] and in surveys taken in three geographic areas, the Mexican-American elderly cited major health-related problems in vision, hearing, and memory. They also cited problems in getting up and down stairs, shopping for groceries, eating solid food, and getting out of the house.[102] Among 64 respondents in Los Angeles who considered themselves disabled, 18 percent designated arthritis and related diseases as the major health problems; 11 percent designated nervousness and debility; 6 percent, accidents and injuries; and 5 percent, cerebrovascular diseases.[103]

The health problems of minority elders are closely linked to their poverty status. In 1975, 36 percent of the black elderly and 33 percent of the Hispanic elderly lived below the poverty level as compared to 13 percent of the white elderly.[104]

Functional impairment as well as self-reported health showed a dramatic relationship to income. In New York, only 39 percent of the inner-city elderly in the lowest income group had no physical impairments, compared to 62 percent and 27 percent of those in the highest income categories.[105] During 1978, the average number of restricted activity days per person aged 65 and over ranged from 53.9 for those with incomes under $3,000 a year to 20.7 for those with annual incomes of $25,000 or more.[106] It follows, then, that income level compels the poor minority elderly to rely on the Medicaid program more heavily than do other segments of the population. They are therefore limited in their ability to obtain high quality medical care by: (1) the special limitation on services that individual states mandate, and (2) physician reluctance to treat Medicaid patients because of low reimbursement levels for services provided.[107]

Minority elderly not only have limited access to high quality care, they also use fewer health services than needed. Specifically Hispanics, Asians, and Indians face cultural and linguistic barriers to obtaining care. An Administration on Aging research report indicated that 13 percent of minorities had problems applying for and 10 percent had problems receiving public benefits.[108] Having to admit that they did not know about possible benefits and procedures for obtaining them, and thereby admitting dependency on others, was a greater barrier to obtaining care than was lack of fluency in English.[109]

Other problems, primarily socio-cultural and including the language barrier, relate to under-utilization of the health care system by minorities. Many Hispanic and Indian elderly do not speak English. Hispanic elderly also do not readily accept assistance from a stranger because outside help is perceived as an intrusion into an individual's intimate and personal life.[110] Folk medicine also plays its role. Among Hispanic elderly, it is still a common practice in several parts of the southwest. Additionally, some Hispanics are undocumented aliens and thus are unable or afraid to use health services except in emergencies. Only now are we beginning to understand these factors.[111]

A final barrier to use of health services by minorities is their under-representation in the health and medical professions. For instance, while minorities comprised 12 percent of the population in 1970 and 11 percent of the employed population, blacks accounted for only 6 percent of the six leading health professions. In 1970 there were only 26.6 black physicians per 100,000

population (compared to 146.4 white physicians per 100,000 population) and only 10.5 black dentists per 100,000 population (compared with 50 white dentists per 100,000 population.[112] There is a particular under-representation of minorities in geriatrics and gerontology.

The problems associated with the minority elderly will intensify as their numbers increase relative to the general population. In several areas of the country, minorities will soon outnumber whites; it is expected that Hispanics will become the largest minority in the country. The proportion of elderly to the general minority population can be expected to increase because of higher fertility rates, declining mortality rates, and increased life expectancy. For the black elderly population, projections show that the overall percentage increase from 1975 to the year 2000 will be 39.1 percent for the 60 to 64 age group, 54.7 percent for the 65 to 74 age group, and 72.4 percent for those over age 75.[113] These projections are higher than for whites with increases of 11.9 percent, 19.8 percent, and 57.3 percent, respectively.[114] The rate increase for Hispanics is even higher. The rate of natural population increase (births over deaths) among Hispanics is 1.8—.6 percent higher than that for blacks.[115] Additionally, immigration is a major factor for Hispanics and Asians as well. Hispanic immigration, legal and illegal, is estimated at a rate of one million persons per year.[116]

II. RECOMMENDATIONS

From a large number of problems noted in the first section, we have identified the most pressing and have formulated recommendations for addressing them. These recommendations are predicated on the firm conviction that the overriding goal of U.S. health policy for the elderly during the 1980's should be quality of life emphasizing maximum functional independence (MFI). Such independence for the maximum number should, in fact, be the major goal of all U.S. policies for the elderly—income maintenance, housing, transportation, societal services—as well as health. It is the common theme that links, or should link, policies and programs in all these areas.

In the health field, this primary goal implies careful attention to how to achieve the least restrictive environment while offering appropriate interventions. It raises issues of our willingness to take the risks of allowing clients to function autonomously and to face the consequent need to protect providers from reprisals, and it recognizes that encouraging a patient to function for himself often requires more effort than to do the job for him.

Because chronic disease and accidents are now the primary causes of death and serious disability among the elderly, we should mount a major effort to eliminate or reduce the major risk factors contributing to them. Television and other mass media should be used to educate elderly consumers about both health behaviors and the most effective ways of using health services.

Stressing MFI as the cornerstone of the national health policy for the elderly does not mean an attack on Medicare or other previous policy commitments. We must preserve Medicare's essential commitment to the best possible acute care but balance it with, and link it to, the best possible preventive and long-term services, at a price that the nation can afford. We must forsake "turf" battles over the alleged superiority of "the medical model" versus the "social model" and combine the strengths of both into a "comprehensive model," which, we hope, is already emerging.

The recommendations that follow all stem from the primary goal of MFI. In accordance with the mandate to our committee, we have naturally emphasized the medical aspects. But it would not be possible to present a meaningful report on health care for the elderly that ignored the related areas of income maintenance, health promotion, and social services, although we have not attempted to flush out the specifics in those areas. This report is *very* cost conscious. While recommending some needed new programs or benefits, it also recommends curtailing others and establishing some essential cost controls.

A. Useful Work. Because physical and mental activity and social involvement are essential to health, the older individual should be encouraged to remain active as long as possible. Public and private institutional arrangements should be adjusted to this end.

Some elderly people prefer to accomplish this through an active retirement, which may include a "second career" or useful volunteer work. Others would prefer to remain on their regular jobs as long as possible, perhaps on a reduced schedule or with fewer responsibilities.

The retirement policies of the Social Security system and of the individual employers should be as flexible as possible. The overall aim should be to encourage and facilitate later retirement while protecting the right to an early retirement for those who are unable to continue working or who want to retire. Social Security has begun to move in this direction through its provisions for early retirement at reduced benefits and retirement deferral credits. These differentials should be increased. For those who can no longer work without impairing their health, adequate retirement income must be assured, primarily through strengthening the Social Security system.

The 1978 amendments to the federal Age Discrimination in Employment Act ban compulsory retirement for most employees before age 70. For successful operation of the new law, however, many employers will need to explore new procedures for individual functional or performance evaluation, more refined job assessment with special attention to the needs of older workers, possibilities for reassignment to more appropriate work, and modification of the work environment to assure the safety and health of elderly employees. Many employees also need assistance and counseling in deciding when and how to retire.

The elderly can be usefully employed in a variety of services to other elderly persons. Volunteer services, especially those built around peer support programs, should be widely promoted and supported both because they are economical and because they can be important to the giver as well as to the receiver.

Consideration should be given to a gradual rise in the normal retirement age from age 65 to age 68 or 70, perhaps at a rate of one year every five years. Higher pensions for those remaining at work after the norm and reductions for early voluntary retirement would also help to achieve this goal. As far as possible, private pension plans should also be adjusted.

B. Primary Care. Each elderly individual should have access to a single source of good primary care. Such care should emphasize responsible and continuing surveillance by a primary-care practitioner, usually a family physician, general internist, or a nurse practitioner or physician's assistant. Periodic preventive services, referral to specialized services (from both physicians and allied health care professionals), long-term and terminal care, and centralized comprehensive medical records are essential components of such primary care.

Comprehensive, easily accessible primary care is the key to effective prevention, linking it to acute care and long-term care. Even when chronic disease and disability are present, the severity of disabling consequences can usually be minimized through good medical management linked with appropriate social services and well-informed, responsible patient and family practices.

1. For each jurisdiction, a responsible body representing both government and the appropriate professional groups in each state should establish a roster of primary-care physicians and other qualified primary-care personnel. This roster would be used as the basis for Medicare reimbursement. Board certification would be considered the primary basis for inclusion in the rosters. In addition, primary practitioners should agree to maintain comprehensive records and to provide essential preventive services, specialized referrals, long-term care and terminal care. Within five years after the program goes into effect, eligible providers would be required to demonstrate special competence in geriatrics. The rosters should be reviewed and updated at least every two years.

2. All Medicare patients should be required, as a condition of reimbursement, to consult with primary-care practitioners before seeking specialized care.

3. The Surgeon-General of the United States, in conjunction with the Institute of Medicine, the relevant certifying boards, and specialty societies or other appropriate advisory bodies, should develop minimum schedule(s) of periodic coordinated health services for the elderly who are well. These guides should be made available to all primary-care practitioners. Such services should include appropriate (1) health assessment, screening, or case-finding procedures; (2) immunizations; and (3) counseling about nutrition, risk-factor reduction, retirement adjustment, adjustment to the death of a spouse, and other potentially traumatic changes.

C. Allied Health Professionals. Each elderly individual should be eligible under Medicare coverage up to a fixed amount for drugs and the services of the major allied health professions. Such services should include: dentistry, vision, hearing, foot care, nutrition, family and personal health counseling, and the services of various rehabilitation therapists.

Timely and appropriate use of the allied health professions is often both health-effective and cost-effective. To minimize abuse, we recommend a fixed dollar limit that the elderly person could use as he or she deemed most appropriate. At the same time, more complex analyses should examine the relative cost-effectiveness of the diverse services covered. This information can provide guidelines to the consumer or may be used for more specific regulations regarding entitlement. The first step would be to establish a list of reimbursable services, by profession, with appropriate limits on use.

D. Medicare Reforms. Title XVIII of the Social Security Act should be amended to carry out the following changes:

1. *Recognize the essential role of primary care, including preventive health services and long-term care, in the health of the elderly; make appropriate administrative arrangements to assure such care, including non-discriminatory reimbursement of providers; repeal the requirement for onsite physician supervision of other approved primary-care practitioners.*

2. *Repeal those provisions of Sec. 1862 that prohibit payment for preventive services and for "orthopedic shoes and other supportive devices for the feet"; provide reimbursement for a defined schedule of periodic, age-specific preventive services; create a defined list of preventive, maintenance, and rehabilitation services to be provided by the allied health professions (with reasonable cost-sharing).*

3. *Increase immediately the ceiling for outpatient psychiatric benefits from an annual maximum of $250 to $1000 and increase from 50 percent to 80 percent Medicare coverage for these services; establish a series of demonstration projects to determine the feasibility of covering mental illness on the same basis as physical illness.*

4. *Establish a limit on cost-sharing for those few patients who have to remain in a hospital more than 60 days or whose combined deductible and coinsurance come to more than $1000 in one year.*

5. *Repeal the provision of Sec. 1862 that prohibits reimbursement for the ill-defined term "custodial care"; recognize the need for continuity between acute and long-term care (both institutional and home-based) and provide Medicare reimbursement (rather than Medicaid) for appropriate long-term care in both types of settings, as determined by the Long-Term Care Assessment and Case-Management Program set forth in Recommendation E; establish conditions of Medicare participation for providers of long-term care (both institutional and home-based) and appropriate cost-sharing formulas between Medicare and long-term care patients; provide for transfer from Medicaid to Medicare of any outstanding federal funds now budgeted for long-term care under Medicaid.*

6. *Shift from retroactive "reasonable costs" reimbursement to negotiated prospective rates as the basis for payment to institutions and from retroactive "reasonableness charges" based on CPR criteria to negotiated prospective rates as the basis for payment to practitioners; require that practitioners elect annually between "participating" and "nonparticipating" status so that beneficiaries can know in advance the percentage of co-payment involved.*

As already noted, Medicare embodies the nation's principal health care policy for the elderly and has performed well in the limited area for which it was primarily intended: accute institutional care. However, with the changing pattern of morbidity and mortality and the now overwhelming need for attention to chronic illness, prevention, and long-term care, Medicare urgently needs reform. The six points listed above by no means exhaust the possibilities, but they do represent areas that need adjustment most. The background and justification for these points have been discussed in earlier sections of this report.

Special emphasis should be placed on the need to improve coverage of mental health services. Throughout this report we have emphasized the mental as well as physical aspects of illness among the aged. It follows that third-party coverage should move toward similar parity of coverage for mental and physi-

cal care. However, because mental health services are provided by so diverse an array of persons and institutions, special problems arise. These problems must be resolved, not ignored. We hope that the changes suggested here for Medicare will be adopted by other third-party payors as well.

E. Long-Term Care Coordinating Service. A new service to coordinate long-term care for the elderly and disabled on a community basis should be established as Title XXI of the Social Security Act.

A major obstacle to good long-term care in the United States is the fragmentation of the entire field. Some cleavages between different professions and orientations are inevitable and probably constructive, but a mechanism for reconciling these differences must be found in the interests of the patient and the society.

We recommend that independent case-management programs be established at the local level to perform three functions:

1. Assure maximum feasible coordination among health care institutions, agencies, and programs involved in care of the elderly;

2. Provide comprehensive assessment, appropriate placement, and cost-effective case-management of the individual patients;

3. Allocate long-term care resources in the most equitable and effective manner.

These programs would have authority over all Medicare and any residual Medicaid patients.

Case managers for these agencies will require special training in gerontology with emphasis on functional status measurement. Case management calls for a new approach, which emphasizes the multidimensionality of the problems the elderly face.[117] By emphasizing functioning along a variety of domains, including physiological, activities of daily living, affective, cognitive, social, economic, and satisfaction, this new approach can support the more customary medical taxonomy. Functional assessment focuses on the outcomes of a number of factors, including the stresses of diseases, the effects of the environment (physical and social), and the interventions of caregivers (formal and informal). It thus represents a summary statement that can incorporate the contributions of a variety of different factors and offers a new way to interpret quality of care.

The precise form of this new program and its relation to Medicare, Medicaid, private insurors, and methods of financing need prompt and careful study.

F. Humane Terminal Care. Humane terminal care should be considered a natural and essential aspect of good health care for the elderly. Appropriate legal, medical, and organizational arrangements should be made to translate this ethical concern into regular medical care. We recommend a three-point program:

1. "Right to die" or "death with dignity" laws, patterned after the Yale model, should be encouraged in all states in addition to those ten where such statutes have been enacted.

2. All hospitals and long-term care facilities should be encouraged to establish a committee consisting of professionals (e.g., physicians, nurses, social workers, clergy) and other appropriate public members to establish guidelines and to counsel the attending professionals advising both the terminally ill patients and their families. These committees would help to protect patients from the dangers of withholding life-saving treatment and would help avoid inappropriate therapeutic effects. Establishing such committees may require some statutory limitations on malpractice liability.

3. The hospice concept should be promoted throughout the nation, especially in areas geographically inaccessible to existing programs. Although the hospice may be hospital-centered, it should emphasize home care and involvement of family and volunteers. Existing excess facilities can often be converted for respite care. The appropriate regulatory agencies should establish both standards of hospice care to serve as a basis for licensure and guidelines for related educational programs.

G. Professional Training in Geriatrics/Gerontology. The rapidly growing consensus about the need for more physicians, nurses, social workers, and other professionals and paraprofessionals with special training in and commitment to geriatrics/gerontology should be promoted and supported by adequate public and private funds for such training and by appropriate adjustment of licensing laws and certification requirements. Particular attention should be directed to the training of minority health professionals.

Although health professionals do not agree about whether we need a new medical specialty of geriatric medicine, consensus grows rapidly about the need for more and better-trained professional personnel through the entire field of health care for the elderly. The lack of professionals, especially physicians, committed to this field has been one of the major obstacles to more rapid progress. This deficit must be corrected if the other reforms advocated in this report are to succeed.

Medical schools and other schools of the health professions are strongly urged to introduce or strengthen teaching programs in geriatrics and gerontology at the undergraduate, graduate, and post-graduate levels. We urgently need continuing education programs for practicing professionals, and federal and state governments must make supplementary funds available for this purpose. Private contributors can augment these funds. Furthermore, special subsidies for geriatric fellowship programs and training programs, prepared by gerontologic faculty in various health professions, should be considered. Nursing homes used for teaching may be helped with special educational payments in their reimbursement formulae. Finally, more attention to geriatrics and gerontology in licensing and certification examinations, using the California CLEX examination as a model, should be explored in other jurisdictions.

H. Research in Geriatrics/Gerontology. Research on the problems of delivering more effective care to the elderly must have more support. Health services research and clinical/epidemiologic information are sorely needed in a number of vital areas.

A number of important unanswered questions have been identified in this report. These questions deal with how health care services can be better organized to meet the needs of the elderly, how more efficiency can be achieved, and where new investements of effort are likely to be most effective. Although basic biomedical research on aging has enjoyed much interest and support, applied research that addresses questions about delivery of care has received less attention. There is a need to develop more meaningful and useful techniques of functional assessment. We need better information on the relative effectiveness of using various configurations of nursing personnel. (Are we better off, for example, with a smaller number of better-paid professionals than with a larger number of aides?) We need more research about the costs and benefits of prevention in the elderly, including immunizations and early detection; we need to know more about the cost-effectiveness of allied health services in prevention and on-going treatment; we must understand the

iatrogenic effects of treatment; and we need more work on predicting the course of elderly patients to help us develop better norms for outcomes. Can we identify subgroups of chronically impaired elderly who are most likely to benefit from specific interventions? Will such interventions prevent or delay costly institutionalization? This is but a partial list of pressing agenda items for health services research in the area of aging.

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Creating an Age Integrated Society: Implications for Spiritual Well-Being
Creating an Age Integrated Society: Implications for the Family
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Research in Aging

Experts from various fields were appointed by the Secretary of Health and Human Services to serve on 16 Technical Committees, each charged with developing issues and recommendations in a particular area for consideration as background material for the delegates to the 1981 White House Conference on Aging.

the 1981
White House
Conference
on
Aging

Executive Summary of
Technical Committee
on
HEALTH SERVICES

TCES-10

NOTE: The recommendations of this document are not recommendations of the 1981 White House Conference on Aging, or the Department of Health and Human Services. This document was prepared for the consideration of the Conference delegates. The delegates will develop their recommendations through the processes of their national meeting in late 1981.

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EXECUTIVE SUMMARY

I. INTRODUCTION

The health experiences of older persons differ considerably from those of other segments of the adult population. Furthermore, the health problems faced by elderly persons today will likely become worse over the next decade as their numbers grow and the resources available to meet these needs shrink. We offer first a list of some of the major problems regarding health services for the elderly in the country and then a set of recommendations designed to address, but not necessarily to redress, the many deficiencies in health care suffered by the aged in this country. The reader is reminded that a fuller discussion of both the problems and the recommendations is available in the parent report from this committee.

II. MAJOR FINDINGS

A. Health Maintenance.

Most of the elderly, especially the "young-old" (age 65 to 74), are relatively healthy and are primarily concerned with maintaining their health.

B. Chronic Illness

Older persons who do become ill are likely to have a mixture of both acute and chronic illnesses and disabilities, in contrast to younger adults, who usually have only single acute illnesses. The multiple illnesses affect multiple organ systems simultaneously, and treatment of one disorder may provoke malfunction in another organ system or aggravate a coexisting disease. The older person with multiple diseases is therefore at greater risk of experiencing over or undertreatment or of having a treatment "misadventure." In addition, the older person frequently does not know precisely where to go for health care services.

In older persons and in the young, manifestations of both acute and chronic illnesses may differ for the same diseases, leading to potential delay and potential misdiagnosis rather than to timely and appropriate treatment and rehabilitation.

Medications used in the treatment of both physical and mental disorders have significantly altered effects in older patients, who often require multiple medications. Drug interactions and adverse drug reactions add to the health care burdens of an already burdened segment of the population.

As currently designed, the health care system does not reach out to older people and inform them how the system can serve them. Thus, elderly persons often do not know where to turn for help, what to look for, or what services they are eligible for. They have no simple way of evaluating the quality of the services they receive.

C. Mental Illness.

Fifteen percent of all older people living in the community and an astonishing 50 to 70 percent of elderly living in institutions suffer from serious mental and/or emotional problems. Mental disorders may be the principal cause of disability among the elderly or they may complicate the health status of those elderly with major physical problems. Mental problems common among the elderly include depression, anxiety states, paranoia, and alcoholism, as well as reversible and irreversible dementias, i.e., serious intellectual and memory disorders. The frequency of suicide, especially among males, greatly exceeds rates experienced by younger persons.

D. Multiple Impairments.

Older persons experiencing health and mental health problems frequently have associated disabilities and impairments including social isolation and financial deprivation. Impairments in these additional areas of functioning can determine whether an individual with physical or mental disorders remains in an independent community setting, or whether he or she must be admitted to an institutional long-term care setting.

E. Demographic Characteristics.

Individual health needs vary greatly but recognized demographic variables, including age, sex, race, income, location, family status, and living arrangements can at least partially help to predict needs. Age is a major factor influencing entry into a nursing home. Sex has now replaced race as the major single factor influencing life expectancy.

F. Manpower.

Major portions of the health care systems in the United States are oriented toward acute illness and the practice of specialty and subspecialty medicine. While these elements are highly developed and may meet some of the health care needs of the elderly, the basic approach does not respond to the regularly expected health care experience of the old. The elderly lack primary medical care. Individuals requiring multiple types of health care services often find such services disarticulated and in separate sections of their communities. Continuity of care is difficult to achieve.

Whereas younger patients with acute illness can find health care providers interested in their problems, elderly patients with their complex health, mental health, social, and economic problems encounter substantial difficulty locating health care providers with the requisite attitudes, interests, knowledge, and skills.

G. Prevention.

There is increasing recognition of the need for preventive programs and services, especially with respect to chronic disease and accidents.

H. Death.

For the dying patient, humane terminal care is often the most pressing need, and it is usually difficult to meet.

I. Medicare.

For most people over age 65, the Medicare experience has been, on the whole, positive. Coverage of acute hospital care is good, of physicians' services, fair. Major deficiencies relate to costs—both to the individual and to society—and to failure to cover preventive and long-term care. This omission has an effect on health and contributes both to the ever-increasing fragmentation of services and to the unacceptable rise in costs. Medicare urgently needs reform.

J. Minorities.

Just as the health experiences of the elderly differ from those of the young, so do the health experiences of the minority elderly, especially of black, Hispanic, or American Indian elderly, differ from those of the majority elderly. Certain elements of the health care system meet their needs even less well than they do those of majority elderly. Thus, some minority elderly will experience age-related health problems and may, in fact, die before attaining the age at which they become eligible for Medicare. In addition, many more minority elderly do not have Medicare and/or Social Security benefits available to them at age 65 due to low earnings during their working years. Limited availability of health care personnel sensitive to language requirements, customs, and social needs of ethnic minorities compounds the problems.

III. RECOMMENDATIONS

A. Useful Work.

Because physical and mental activity and social involvement are essential to health, the older individual should be encouraged to remain active as long as possible. Public and private institutional arrangements should be adjusted to this end.

B. Primary Care.

Each elderly individual should have access to a single source of good primary care. Such care should emphasize responsible and continuing surveillance by a primary-

care practitioner, usually a family physician, general internist, or a nurse practitioner or physician's assistant. Periodic preventive services, referral to specialized services (from both physicians and allied health care professionals), long-term and terminal care, and centralized comprehensive medical records are essential components of such primary care.

C. Allied Health Professionals.

Each elderly individual should be eligible under Medicare coverage up to a fixed amount for drugs and the services of the major allied health professions. Such services should include dentistry; vision; hearing; foot care; nutrition, family and personal health counseling; and the services of the various rehabilitation therapists.

D. Medicare Reforms.

Title XVIII of the Social Security Act should be amended to carry out the following changes:

1. Recognize the essential role of primary care, including preventive health services and long-term care, in the health of the elderly; make appropriate administrative arrangements to assure such care, including non-discriminatory reimbursement of providers; repeal the requirement for onsite physician supervision of other approved primary-care practitioners.
2. Repeal those provisions of Sec. 1862 that prohibit payment for preventive services and for "orthopedic shoes or other supportive devices for the feet"; provide reimbursement for a defined schedule of periodic, age-specific preventive services; create a defined list of preventive, maintenance, and rehabilitation services to be provided by the allied health professions (with reasonable cost-sharing).
3. Increase immediately the ceiling for outpatient psychiatric benefits from an annual maximum of $250 to $1000 and increase from 50 percent to 80 percent Medicare coverage for these services; establish a series of demonstration projects to determine the feasibility of covering mental illness on the same basis as physical illness.
4. Establish a limit on cost-sharing for those few patients who have to remain in a hospital more than 60 days or whose combined deductible and coinsurance come to more than $1000 in one year.
5. Repeal the provision of Sec. 1862 that prohibits reimbursement for the ill-defined term "custodial care"; recognize the need for continuity between acute and long-term care (both institutional and home-based) and provide Medicare reimbursement (rather than Medicaid) for appropriate long-term care in both types of settings, as determined by the Long-Term Care Assessment and Case-Management Program set forth in Recommendation E; establish conditions of Medicare participation for providers of long-term care (both institutional and home-based) and appropriate cost-sharing formulas between Medicare and long-term care patients; provide for transfer from Medicaid to Medicare of any outstanding federal funds now budgeted for long-term care under Medicaid.

6. Shift from retroactive "reasonable costs" reimbursement to negotiated prospective rates as the basis for payment to institutions and from retroactive "reasonable charges" based on CPR criteria to negotiated prospective rates as the basis for payment to practitioners; require that practitioners elect annually between "participating" and nonparticipating" status so that beneficiaries can know in advance the percentage of co-payment involved.

E. Long-Term Care Coordinating Service.

A new service to coordinate long-term care for the elderly and disabled on a community basis should be established as Title XXI of the Social Security Act.

F. Humane Terminal Care.

Humane terminal care should be considered a natural and essential aspect of good health care for the elderly. Appropriate legal, medical, and organizational arrangements should be made to translate this ethical concern into regular medical care.

G. Professional Training in Geriatrics/Gerontology.

The rapidly growing consensus about the need for more physicians, nurses, social workers, and other professionals and paraprofessionals with special training in and commitment to geriatrics/gerontology, should be promoted and supported by adequate public and private funds for such training, and by appropriate adjustment of licensing laws and certification requirements. Particular attention should be directed to the training of minority health professionals.

H. Research in Geriatrics/Gerontology.

Research on the problems of delivering more effective care to the elderly must have more support. Health services research and clinical/epidemiologic information are sorely needed in a number of vital areas.

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